MAIL COMPLETED APPLICATION PACKAGE TO:
Office of Regulatory Services
Personal Care Home Program
2 Peachtree Street, N.W.
Suite 31.447
Atlanta, Georgia 30303-3167

Home Name _____ **Number of Residents** _____

Home Address _____

Community Living Arrangement (CLA) Application Checklist

A complete Application Package for a Community Living Arrangement permit includes the following:

___ 1. Application – completed and signed by the Governing Body Representative
If a corporation – include Certificate of Incorporation and Articles of Incorporation for **ALL** corporations having an interest in the CLA
If partnership – include Partnership Agreement
If Limited Liability Company (LLC) - include Certificate of Organization and Articles of Organization for ALL LLCs with an interest in the residence
If a non-profit – include documentation of non-profit status [5O1(c)3]

___ 2. A completed Letter of Verification from the MHDDAD Regional Office that the residence meets the definition of a CLA and the approved number of residents

___ 3. An original completed Affidavit of Personal Identification

___ 4. A copy of Proof of Ownership for the property or a copy of the Lease Agreement

___ 5. A fingerprint record check for all employees, all adults (18 and older) in the home and all owners (10% or more interest in the home).

___ 6. Fire Safety Inspection Report from the appropriate fire safety authority with no violations or hazards identified and the occupant load noted by the inspector

___ 7. Electrical Service Inspection Report from a Georgia licensed electrician with no violations or hazards identified and the electrician's State license number noted on the report

___ 8. Floor Sketch (including labeling of all rooms, room measurements, location of all doors, windows and bed placement for residents, family and staff)

___ 9. Personal Care Home/CLA Owner Survey Form signed and dated by the Governing Body Representative

___ 10. Written approval for water source and sewage disposal system or a copy of the last water/sewer bill

___ 11. A copy of the required fourteen Policies and Procedures, the Disaster Preparedness Plan, and a Disaster Plan Overview **NOTE: (These documents will <u>NOT</u> be returned.)**

___ 12. A copy of the Admission Agreement to be used by the CLA.

___ 13. Written directions to the residence from Atlanta

NOTE: When all of the above information has been submitted, an ORS surveyor will conduct an unannounced on-site inspection.

Disaster Plan Overview

Facility Name: _____ Address: _____
City: _____ County: _____ Phone: _____
Facility email address: _____ Fax: _____
Licensed Capacity: _____ Number of Residents: _____

Owner: _____ Emergency Contact # _____
Admin/Manager: _____ Emergency Contact #: _____

Emergency Generator: _____ Yes _____ No
Emergency Water Supply: _____ days Source: _____
Emergency Food Supply: _____ days

Evacuation Plan

Transfer Destination(s) – Complete all information for <u>each</u> location, if more than one: Include type of facility (i.e. PCH, NH, Hospital, etc.)/name of facility/city/contact person/telephone# of location(s):

Type of Facility	Name of Facility	City	Contact Person	Phone Numbers

Current, signed transfer agreement: ____Yes ____No If yes, please attach a copy for each facility.

Mode(s) of transportation – Complete all information for each mode of transportation to be used: [Modes of transportation include emergency vehicles (i.e. ambulances) (EV), non-emergency vehicles (NEV), private vehicles (PV) or other (please specify type).] Also include the estimated number of residents to be transported by mode, name of transportation company or agency, city, contact person and telephone number.

Mode of Trans	Est # of Res	Name of Company/Agency	City	Contact Person	Phone Numbers

Current, signed transportation agreement: _____ Yes _____ No. If yes, please attach a copy.

Estimated travel time to receiving facility: _____
Will staff accompany residents during transfers? _____
Will staff provide care and supervision at receiving facility? _____

Are provisions made for snacks, food, beverages, medications and assistive devices that may be needed during transfer for each resident? _____

_____ _____

Signature and title of person completing form

DISASTER PREPAREDNESS PLAN CHECKLIST

Facility:_____ County: _____

_

Date Reviewed:_____ Surveyor:_____

1. Is the plan approved by person/persons legally responsible for facility's operation. Yes___ No___

2. Does the plan designate who has primary responsibility for rehearsals and implementation of plan?
Yes___No___

3. Does the plan stipulate that any subsequent change be forwarded to the Department for approval?
Yes___No___

4. Does the plan identify emergency situations to be addressed? And for each emergency situation does the plan identify how the emergency procedures are to be carried out? Yes___No___

	Emergencies Identified	Procedures Identified
A. Fire	Yes_____No_____	Yes_____No_____
B. Explosion	Yes_____No_____	Yes_____No_____
C. Bomb Scare	Yes_____No_____	Yes_____No_____
D. Missing Resident	Yes_____No_____	Yes_____No_____
E. An interruption of each utility		
1. Electricity	Yes_____No_____	Yes_____No_____
2. Gas	Yes_____No_____	Yes_____No_____
3. Other Fuel	Yes_____No_____	Yes_____No_____
4. Water	Yes_____No_____	Yes_____No_____
F. Loss of:		
1. Air Conditioning	Yes_____No_____	Yes_____No_____
2. Heat	Yes_____No_____	Yes_____No_____
G. Floods	Yes_____No_____	Yes_____No_____
H. Severe Weather	Yes_____No_____	Yes_____No_____
I. Physical Damage to Facility	Yes_____No_____	Yes_____No_____

5. Does the plan contain written procedures which address:

A. Assigning responsibility to staff members	Yes_____No_____
B. Care of residents	Yes_____No_____
C. Notification of resident physician and responsible party	Yes_____No_____
D. Arrangement of transportation & hospitalization	Yes_____No_____
E. Availability of appropriate records	Yes_____No_____
F. Alternate living arrangements	Yes_____No_____
G. Emergency energy sources	Yes_____No_____

6. Does the plan outline:

A. Frequency of Rehearsals	Yes_____No_____
B. Procedures to follow during rehearsals	Yes_____No_____

7. If plan is contingent on services/resources of other agencies/facilities/institutions, a written agreement with each agency is attached to plan. Yes_____No_____

8. Does plan contain statement the Department will be notified within 24 hours if an emergency situation occurs which dictates implementation of plan and results in injury or loss of life. Yes_____No_____

9. Does plan stipulate that when other emergency situations dictate implementation of plan, a written incident report and critique of performance under that plan be done. Yes_____No_____

Approved by Surveyor: _____ Date Approved: _____

COMMUNITY LIVING ARRANGEMENTS
POLICIES AND PROCEDURES CHECKLIST

Name of Residence _____Survey Date_____

County _____ Surveyor _____

Check "YES" or "NO" to determine if residence has a set of policies and procedures that are acceptable to the Department. The policies and procedures can not violate Resident's Rights or other laws or regulations.

POLICY AND PROCEDURE	YES	NO	COMMENTS
1. A description of the services the residence intends to provide. **[see Rule .13]**			
2. How the residence ensures that it does not admit or retain residents who require more care than the residence can provide. **[see Rule .16(1)]**			
3. How the residence guarantees the rights of residents. **[see Rule .19]**			
4. How the residence supervises medications. **[see Rule .20]**			
5. Procedures for reporting and investigating abuse, neglect, exploitation, incidents, injuries, and changes in a resident's condition, including death. **[see Rule .24 and .25]** a How the residence handles a change in a resident's condition: 1) Obtain needed care 2) Notify family 3) Keep records 4) Investigate cause of accident 5) Maintain incident reports on file. b. How the home handles the death of a resident: 1) Notify physician, family, etc. 2) How/when money is refunded c. How the residence handles A/N/E: 1) Staff immediately report to ORS 2) Staff immediately notify law enforcement 3) Staff follows MHDDAD reporting protocol			
6. How the residence handles admissions. **[see Rule .16(2-4)]**			
7. Procedures for discharge/transfers and expedited /transfers of residents. **[see Rule .26 and .27]** a. Discharges/transfers: 1) 30 day notice except for emergencies 2) Transfers of record b. Expedited transfer of residents: 1) Under what conditions 2) Based on written admissions 3) Defines responsibilities 4) Discharge Planning			
8. How the residence handles refunds when a			

resident is transferred, discharged or dies. **[See Rule .17(1) (c)]**			
9. Expectations regarding cooperative living address the following: **[see Rule .17(1) (e)]** a. Sharing of common space; other resources b. Use of tobacco c. Use of alcohol d. Explanation of items prohibited by the CLA			
10. The quality assurance procedures used to maintain or improve the quality of care and services provided to the residents. **[see Rule .07(3) (j)]** a. Performance Indicators: 1) Routinely measured and Evaluated. 2) Measurements and Improvement of any injury.			
11. How the residence will ensure that staff are trained. **[See Rule .15(3)]**			
12. How the residence handles acts committed by staff or residents that are inconsistent with policies of the residence. **[See Rule .15(1; 10) and .17(1) (e)]**			
13. How the residence will manage the use of medical protection devices and adaptive support devices. **[see Rule .21(1-7)]** (1) Documentation that the least restrictive methods/devices were evaluated and determined to be appropriate.			
(2) Assessment in file describing and supporting need(s)for device.			
(3) MD order in file including the following: a) No longer than 180 days or six calendar months b) Type of device c) Rationale for use d) Duration e) Plan for reduction f) Instructions for release and monitoring g) MD exam prior to reordering			
(4) Use of device discussed in advance with resident and legal guardian, if any.			
(5) Use of device is specified in ISP.			
(6) Staff trained in the application of the device and care of the resident(s) to whom device is applied.			
(6) RN or appropriate health care professional assesses resident at least once per quarter with documentation of findings in file.			
(7) Devices shall be: a. Authorized in ISP			

b. Kept clean and used to cause no harm c. Inspected to ensure in good repair d. Discontinued when no longer needed			
. (9) Use of device shall be monitored by staff to ensure that terms of the order are followed and used approximately.			
(10) Training updated annually to reflect staff competency.			
(11)No use of chemical, mechanical, and seclusion under any circumstances.			
14. How the residence will manage the use of personal restraint and quiet time. **[See Rule .22]** (1) Specified in the ISP			
(2) Emergency Care Plan in place			
(3) Ineffective interventions prior to use of restraints documented.			
(4)(6) Restraint time no longer than one hour for personal restraint.			
For personal restraints: a. Door left open; checked every 15 minutes and documented; pressure sites checked every 15 minutes b. Resident spoken to; checked for indications of distress; offered water; provided opportunity to meet bathroom needs. c. Food offered if restraint used during meal times.			
(7) Notification to MHDDAD and legal guardian within 24 hrs of use of personal restraints and documented in file.			
(8) Adverse change of condition documented.			
(9)(10) For Quiet Time: Documented in ISP. Use documented in sequence. Staff identified.			
(11) Use of Quiet Time should not exceed 15 minutes.			
(12) Quiet time conducted in unlocked, well-lighted, well-ventilated area with observation.			
(13) Quiet time and personal restraint use must be monitored and evaluated to ensure steps taken to minimize or eliminate need.			

Approved by: _____ **Date:** _____

Georgia Department of Human Resources
Community Living Arrangements

COMPLIANCE SELF TEST

This list is enclosed to assist you in evaluating your residence in terms of the Rules and Regulations for Community Living Arrangements, Chapter 290-9-37. **It is NOT an all-inclusive list** but covers many areas in the rules. This is not intended to be part of your application package but to help you ensure that the facility meets the rules necessary to obtain a permit and is prepared for the initial inspection by Office of Regulatory Services staff.

Y	N	
❑	❑	1. I understand that as the Governing Body, I am responsible for making sure the residence is in compliance with the rules and regulations at all times.
❑	❑	2. I have developed all required policies and procedures. All policies and procedures are appropriate to the size of the residence and the resident population. Minimum policies and procedures include the following:
❑	❑	a. What services the residence intends to provide.
❑	❑	b. How the residence ensures that it does not admit or retain persons who require more care than the residence can provide.
❑	❑	c. How the residence guarantees the rights of residents.
❑	❑	d. How the residence supervises medications.
❑	❑	e. Procedures for reporting and investigating abuse, neglect, exploitation, incidents, injuries, and changes in a resident's condition, including death.
❑	❑	f. How the residence handles admissions.
❑	❑	g. Procedures for discharge/transfers and expedited/transfers of residents.
❑	❑	h. How the residence handles refunds when a resident is transferred, discharged or dies.
❑	❑	i. Expectations regarding cooperative living.
❑	❑	j. The quality assurance procedures used to maintain or improve the quality of care and services provided to the residents.
❑	❑	k. How the residence will ensure that staff are trained.
❑	❑	l. How the residence handles acts committed by staff or residents that are inconsistent with policies of the residence.
❑	❑	3. The residence has developed a written disaster preparedness plan.
❑	❑	4. The residence has a currently listed telephone number and a non-pay working telephone that is accessible at all time for emergency use by staff and residents in a private location to make and receive personal calls.
		5. The residence meets the following physical plant requirements:
❑	❑	a. The residence is constructed, arranged, and maintained to provide adequately for the health, safety, access, and well-being of the resident.
❑	❑	b. Windows and doors used for ventilation have screens that are in good repair.
❑	❑	c. The residence has installed supportive devices as necessary to enable residents to achieve a greater degree of mobility and safety from falling.
❑	❑	d. The residence has laundering facilities on the premises.
❑	❑	e. Floor coverings do not present a tripping hazard.
❑	❑	f. Furnishings are clean and in safe, usable condition.
❑	❑	g. Lighting fixtures are sufficient for reading and other activities.
❑	❑	h. The residence has adequate heating/cooling system to ensure that temperatures are maintained at 65-80 degrees Fahrenheit year round.

❑ ❑ i. The residence and grounds are clean and free of rodents, flies, vermin, nuisances, hazards, refuse and litter.

❑ ❑ j. The house number is displayed and easily visible from the street.

6. The residence meets the following requirements for the living and dining area(s):

❑ ❑ a. There is at least one centrally located living room for the free access and informal use of the residents.

❑ ❑ b. The living room(s) is large enough to accommodate residents without crowding.

❑ ❑ c. The residence has an area for use by residents and visitors which affords privacy.

❑ ❑ d. The living and dining areas are large enough to accommodate all residents without crowding.

❑ ❑ 7. The residence has a means of providing locked storage for any residents' valuables or personal belongings when requested.

8. All bedrooms meet the following requirements:

❑ ❑ a. Sleeping areas adjoin living areas of the home.

❑ ❑ b. Bedrooms provide sufficient floor space per resident without crowding.

❑ ❑ c. Bedrooms have at least one-half of the room height above ground level.

❑ ❑ d. There is no more than one resident per bedroom unless adequate bedroom space is available for two residents to accommodate without crowding.

❑ ❑ e. Bedrooms have at least one window opening easily to the outside.

❑ ❑ f. Bedrooms are well ventilated and maintained at a comfortable temperature.

❑ ❑ g. Family members, staff and residents each have their own separate designated bedrooms.

❑ ❑ h. Duplicate keys are available to the residents and staff for any residents in single-occupancy bedrooms.

9. Bathrooms meet the following requirements:

❑ ❑ a. At least one functional toilet and lavatory is provided for each four residents.

❑ ❑ b. At least one fully handicap accessible bathroom is available if any resident requires handicap access.

❑ ❑ c. Toilets, bathtubs, and showers provide for individual privacy.

❑ ❑ d. Each bathroom has either forced ventilation to the outside or a window that opens easily.

❑ ❑ e. Bathroom plumbing and fixtures are in good working order and presents a clean and sanitary appearance.

10. Each resident bedroom has the following:

❑ ❑ a. An adequate closet or wardrobe,

❑ ❑ b. Lighting fixtures sufficient for reading and other activities.

❑ ❑ c. A bureau, dresser or the equivalent,

❑ ❑ d. A mirror appropriate for grooming,

❑ ❑ e. An individual bed with comfortable springs and mattress,

❑ ❑ f. Bedding for each resident.

❑ ❑ 11. The residence has a provision to allow residents to personalize their bedrooms with the use of their own furniture, pictures, etc.

12. The residence meets the following safety requirements:

❑ ❑ a. At least one charged 5lb. Multipurpose ABC fire extinguisher is available on each floor and in the basement.

❑ ❑ b. The residence has sufficient smoke detectors that are hard wired to the residence's electrical system and have a battery back-up.

❑ ❑ c. The residence does not have exterior doors that required the use of a key to exit from the inside.

❑ ❑ d. Poisons, caustics and other dangerous materials are properly stored and safeguarded.

❑ ❑ e. Hot water temperatures do not exceed 120 degrees Fahrenheit at the point of use by residents.

❑ ❑ 13. Trash is removed as needed from the kitchen and at least weekly from the premises.

❑ ❑ 14. I have documentation available to show that pets have current inoculations.

❑ ❑ 15. First aid materials are available for use.

❑ ❑ 16. Soap is provided at each sink and toilet tissue at each commode.

❑ ❑ 17. Activities are provided to promote the physical, mental and social well-being of each resident.

❑ ❑ 18. I understand that I cannot restrict a resident's access to the common areas of the residence or lock the resident into or out of the resident's bedroom.

❑ ❑ 19. I will ensure that sufficient staff is available at all times to evacuate the residents in case of an emergency and to ensure the provision of services required.

a. At a minimum, a staffing ratio sufficient to ensure that all residents can be evacuated from the residence within three minutes.

❑ ❑ 20. I have a monthly work schedule for all employees, including relief workers. The schedule shows adequate coverage for the resident population.

❑ ❑ 21. The administrator or site manager is at least 21 years of age. Other staff members are at least 18 years of age.

❑ ❑ 22. Staff has been assigned duties consistent with their position, training and experience.

❑ ❑ 23. At least one staff person having completed the minimum training requirements is in the residence at all times.

24. A personnel file is available for review in the residence for each employee and contains the following

❑ ❑ a. Evidence of a satisfactory fingerprint record check determination from the DHR OIS.

❑ ❑ b. Evidence of a satisfactory criminal records check determination from the local law enforcement (police department) using the GCIC system.

❑ ❑ c. Evidence of TB screening.

❑ ❑ d. Evidence of current certification in CPR and first aid and evidence of training in emergency evacuation procedures, medical and social needs and characteristics of the resident populations, ethics and cultural competence and appropriateness, techniques of de-escalating and techniques to prevent behavioral crises, techniques of Standard Precautions and medication of residents.

❑ ❑ e. Evidence of 16 hours of continuing education yearly.

❑ ❑ f. Employment history for the past five years.

25. A written admission agreement has been developed which contains the following:

❑ ❑ a. A current statement of all fees or charges and services to be provided.

❑ ❑ b. A provision for 60 days written notice prior to changes in services or charges.

❑ ❑ c. Designation of responsibility for initial acquisition and refilling of medications.

❑ ❑ d. A statement of the residence's refund policy.

❑ ❑ e. A written copy of expectations regarding cooperative living, with evidence of of review by residence.

❑ ❑ f. A statement about the responsibility by the Community Living Arrangement for the resident's valuables and other personal belongings .

26. An individual file for each resident maintained in chronological order and contain the following information at a minimum:

❑ ❑ a. Identifying information.

❑ ❑ b. Next of kin, legal guardian, representative payee, etc.

❑ ❑ c. Name, address, phone number and relationship of person(s) to contact in an emergency.

❑ ❑ d. Physician, hospital and pharmacy name address, phone number.

❑ ❑ e. Record of all monies and valuables entrusted to the home for safekeeping.

❑ ❑ f. Health information including physical exam and TB screening.

❑ ❑ g. Personal items inventory.

❑ ❑ h. Signed copy of residents' right form.

❑ ❑ i. Signed copy of the admission agreement.

❑ ❑ j. Copy of the resident's living will and/or durable power of attorney for health care.

❑ ❑ k. Copy of the resident's individual service plan.

❑ ❑ l. Summary of any incident, accident, or adverse change in resident's condition.

❑ ❑ 27. I understand residents' rights and acknowledge that these rights cannot be waived.

❑ ❑ 28. The home stores medications under lock and key.

❑ ❑ 29. I keep a record to document assistance with medications as provided by staff.

30. The home meets the following requirements for nutrition and food service:

❑ ❑ a. I provide three nutritious meals and two nutritious snacks each day.

❑ ❑ b. The temperature of each refrigerator is 41 degrees Fahrenheit or below.

❑ ❑ c. The temperature of each freezer is 0 degrees Fahrenheit or below.

❑ ❑ d. Records of meals served are maintained for 30 days.

❑ ❑ e. I have a three day supply of non-perishable foods for emergency needs.

❑ ❑ 31. I keep a summary of all incident reports including follow-up and notifications.

32. I have the following items available for inspection in my home:

❑ ❑ a. Evacuation Plan on each floor.

❑ ❑ b. Copy of cooperative living expectations.

❑ ❑ c. Most recent inspection report.

❑ ❑ d. Permit to operate a Community Living Arrangement Residence issued by ORS.

❑ ❑ e. Ombudsman Poster.

33. The residence has met the following requirements for inspections:

❑ ❑ a. The residence has been inspected by the appropriate fire department and has no outstanding fire safety violations.

❑ ❑ b. A Georgia licensed electrician has inspected the residence within six months of the application date and found no electrical hazards.

❑ ❑ c. Water supply and sewage disposal systems that are not part of an approved county or city system have been approved by the county public health department.

❑ ❑ 34. The residence has met all local requirements. Local requirements vary and may include the following: business license, zoning approval, etc.

❑ ❑ 35. I understand that I and all staff must report suspected abuse, neglect or exploitation to the ORS.

❑ ❑ 36. I understand that as a licensed home, my residence will be subjected to unannounced inspection visits and that I will cooperate with any investigation.

❑ ❑ 37. FOR FACILITIES WITH MORE THAN 24 RESIDENTS:

a. A Letter of Intent has been approved by the Department of Community Health Planning.
b. A food service permit has been obtained from the county public health department.